Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHARLES E. GEORGE, MD
PO BOX 741865
DALLAS TX 75374

Respondent Name

HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-0951-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DD EXAMS"

Amount in Dispute: $572.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Dispute notice was sent on December 01, 2010. No response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2010	99456-RE-W8 and 95851	$572.06	$572.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203 sets out Medical Fee Guidelines for Professional Services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 26, 2010
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

- BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL

Explanation of benefits dated October 21, 2010
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL

Issues

1. Has the DWC requested Designated Doctor (DD) Extent of Injury (EXT) determination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Was the Range of Motion (ROM) performed in conjunction with an EXT determination of the DD evaluation reimbursed appropriately?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204, the DD performed the EXT exam as requested. The service has been billed and documented appropriately. The MAR for this service is $500.00 and was not paid appropriately.
2. Per 28 Texas Administrative Code §134.204(k), testing shall be billed using the appropriate CPT codes & reimbursed in addition to the examination. Review of the documentation shows ROM CPT code 95851 billed with 3 units of (ROM) measurement was performed to the cervical spine as well as to bilateral shoulders. These were done in support of a Designated Doctor exam for determination of extent of injury (99456-W6-RE) and are payable per 28 Texas Administrative Code §134.204.
3. Per 28 Texas Administrative Code §134.203(c), the MAR is calculated for the zip code 79925 for El Paso, TX (El Paso County-REST OF TEXAS). The MAR for 3 units of CPT code 95851 is $72.22. As the Requestor has disputed $72.06, the requested amount is recommended for this line item as it was not paid appropriately.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $572.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $572.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 28, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.